

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

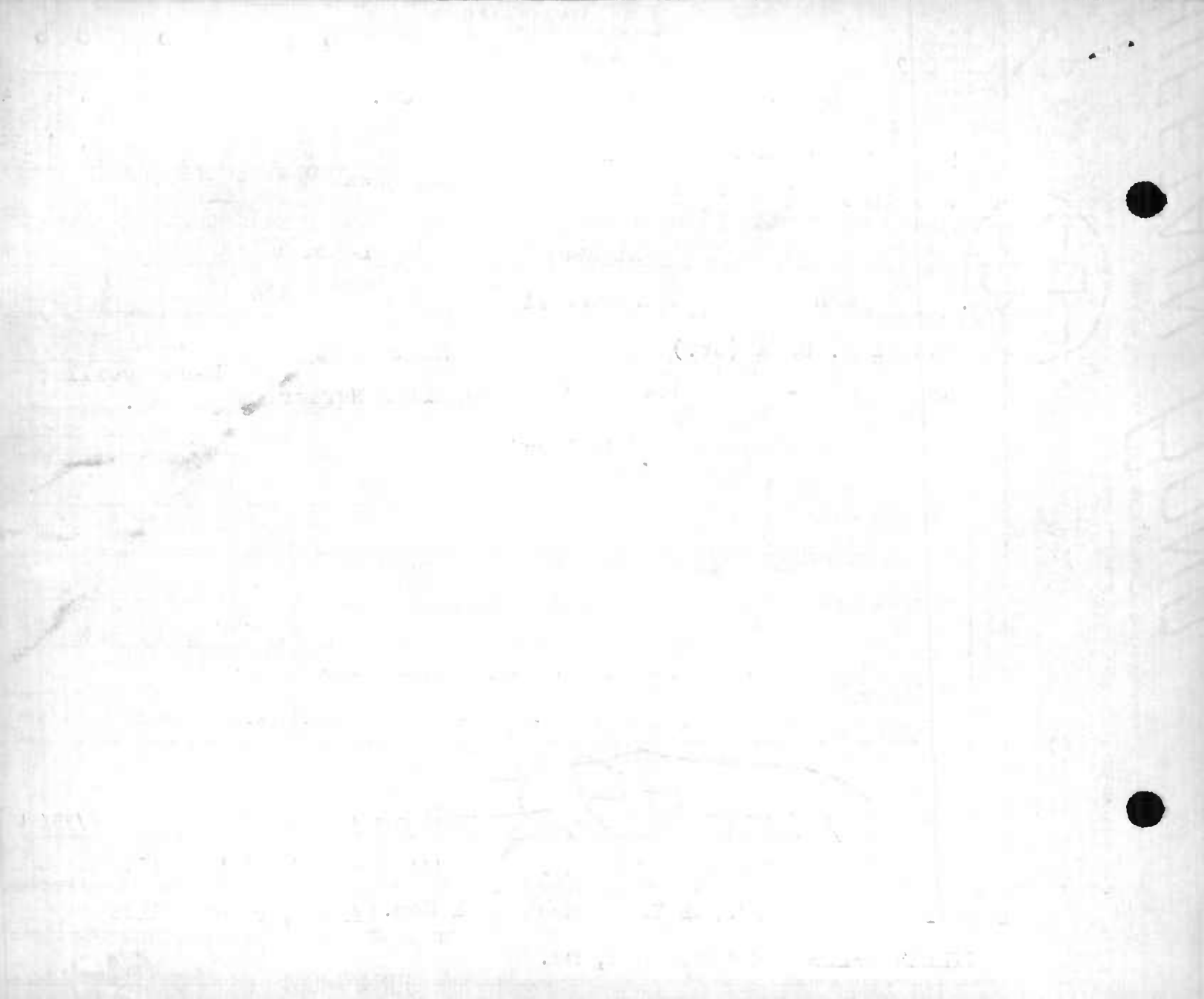
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH	2c. DATE OF DEATH	2d. DATE OF DEATH	2e. DATE OF DEATH	2f. DATE OF DEATH	2g. DATE OF DEATH	2h. DATE OF DEATH	2i. DATE OF DEATH	2j. DATE OF DEATH	2k. DATE OF DEATH	2l. DATE OF DEATH	2m. DATE OF DEATH	2n. DATE OF DEATH	2o. DATE OF DEATH	2p. DATE OF DEATH	2q. DATE OF DEATH	2r. DATE OF DEATH	2s. DATE OF DEATH	2t. DATE OF DEATH	2u. DATE OF DEATH	2v. DATE OF DEATH	2w. DATE OF DEATH	2x. DATE OF DEATH	2y. DATE OF DEATH	2z. DATE OF DEATH
Manuel Angel Baez Jr.					6	25	1981	6	25	1981	6	25	1981	6	25	1981	6	25	1981	6	25	1981	6	25	1981	6	25	1981	6	25	1981
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. AGE (IN YEARS)	8. AGE (IN YEARS)	9. AGE (IN YEARS)	10. AGE (IN YEARS)	11. AGE (IN YEARS)	12. AGE (IN YEARS)	13. AGE (IN YEARS)	14. AGE (IN YEARS)	15. AGE (IN YEARS)	16. AGE (IN YEARS)	17. AGE (IN YEARS)	18. AGE (IN YEARS)	19. AGE (IN YEARS)	20. AGE (IN YEARS)	21. AGE (IN YEARS)	22. AGE (IN YEARS)	23. AGE (IN YEARS)	24. AGE (IN YEARS)	25. AGE (IN YEARS)	26. AGE (IN YEARS)	27. AGE (IN YEARS)	28. AGE (IN YEARS)	29. AGE (IN YEARS)	30. AGE (IN YEARS)	31. AGE (IN YEARS)	32. AGE (IN YEARS)	33. AGE (IN YEARS)	34. AGE (IN YEARS)
Male	Hispanic	1/12/63	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH		11. BALTIMORE CITY OR COUNTY OF DEATH		12. BALTIMORE CITY OR COUNTY OF DEATH		13. BALTIMORE CITY OR COUNTY OF DEATH		14. BALTIMORE CITY OR COUNTY OF DEATH		15. BALTIMORE CITY OR COUNTY OF DEATH		16. BALTIMORE CITY OR COUNTY OF DEATH		17. BALTIMORE CITY OR COUNTY OF DEATH		18. BALTIMORE CITY OR COUNTY OF DEATH		19. BALTIMORE CITY OR COUNTY OF DEATH		20. BALTIMORE CITY OR COUNTY OF DEATH		21. BALTIMORE CITY OR COUNTY OF DEATH		22. BALTIMORE CITY OR COUNTY OF DEATH	
Puerto Rico	Puerto Rico USA	Never married		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.		Kent County, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY		14. KIND OF BUSINESS OR INDUSTRY		15. KIND OF BUSINESS OR INDUSTRY		16. KIND OF BUSINESS OR INDUSTRY		17. KIND OF BUSINESS OR INDUSTRY		18. KIND OF BUSINESS OR INDUSTRY		19. KIND OF BUSINESS OR INDUSTRY		20. KIND OF BUSINESS OR INDUSTRY		21. KIND OF BUSINESS OR INDUSTRY		22. KIND OF BUSINESS OR INDUSTRY		23. KIND OF BUSINESS OR INDUSTRY		24. KIND OF BUSINESS OR INDUSTRY		25. KIND OF BUSINESS OR INDUSTRY		26. KIND OF BUSINESS OR INDUSTRY	
Crumpton	Rt. 290 Highway	Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer		Laborer	
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS	14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. ADDRESS		21. ADDRESS		22. ADDRESS		23. ADDRESS		24. ADDRESS		25. ADDRESS		26. ADDRESS		27. ADDRESS	
Md.	Kent	YES	RFD	Manuel A. Baez (Sr.)		Nirea Lopez		no		584 43 3047		Angelica Nurseries		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. ADDRESS		21. ADDRESS		22. ADDRESS		23. ADDRESS		24. ADDRESS		25. ADDRESS		26. ADDRESS		27. ADDRESS		28. ADDRESS		29. ADDRESS	
Manuel A. Baez (Sr.)		Nirea Lopez		no		584 43 3047		Angelica Nurseries		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. ADDRESS		21. ADDRESS		22. ADDRESS		23. ADDRESS		24. ADDRESS		25. ADDRESS		26. ADDRESS		27. ADDRESS		28. ADDRESS		29. ADDRESS		30. ADDRESS		31. ADDRESS	
no		584 43 3047		Angelica Nurseries		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.		Kennedyville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. CAUSE OF DEATH		20. CAUSE OF DEATH		21. CAUSE OF DEATH		22. CAUSE OF DEATH		23. CAUSE OF DEATH		24. CAUSE OF DEATH		25. CAUSE OF DEATH		26. CAUSE OF DEATH		27. CAUSE OF DEATH		28. CAUSE OF DEATH		29. CAUSE OF DEATH		30. CAUSE OF DEATH		31. CAUSE OF DEATH		32. CAUSE OF DEATH		33. CAUSE OF DEATH	
PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (b)		IMMEDIATE CAUSE (c)		IMMEDIATE CAUSE (d)		IMMEDIATE CAUSE (e)		IMMEDIATE CAUSE (f)		IMMEDIATE CAUSE (g)		IMMEDIATE CAUSE (h)		IMMEDIATE CAUSE (i)		IMMEDIATE CAUSE (j)		IMMEDIATE CAUSE (k)		IMMEDIATE CAUSE (l)		IMMEDIATE CAUSE (m)		IMMEDIATE CAUSE (n)		IMMEDIATE CAUSE (o)	
8147		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries	
2. 8147		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries		Multiple injuries	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (d) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (e) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (f) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (g) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (h) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (i) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (j) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (k) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (l) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (m) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (n) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (o) stating the underlying cause last.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS		OTHER SIGNIFICANT CONDITIONS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?		20. AUTOPSY?	
				YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES	
21a. EXTERNAL CAUSE WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED		21c. HOW INJURY OCCURRED	
OR CONTRIBUTING CAUSE OF DEATH		12:45 PM X 6 25 1981		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto		Pedestrian struck by auto	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION		21f. LOCATION	
NOT WHILE AT WORK		road		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290		Rt. 290	
22a. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22b. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22c. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22d. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22e. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22f. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22g. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22h. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22i. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22j. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22k. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22l. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22m. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22n. I certify that I took charge of the deceased described above, and in my opinion death resulted from		22o. I certify that I took charge of the deceased described above, and in my opinion death resulted from			
Nature causes		Accident		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide		Suicide	
Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.		Thomas D. Smith, M.D.	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED	
Thomas D. Smith, M.D.		Deputy Chief		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81		6/25/81	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS	
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.		111 Penn St. Balto., MD.	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION		23d. LOCATION	
Burial		6/30/81		Yauco Municipal Cem.		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico		Yauco, Puerto Rico	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
WILLIS WELLS		JUN 30 1981		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.		Chester town, Md.	

JUN 30 1981



FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elmer Lewis Bolt			2a. DATE OF DEATH MONTH DAY YEAR June 4, 1981			2b. HOUR P 9:08 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. Willis		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	
12b. KIND OF BUSINESS OR INDUSTRY Farming		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Caroline 13c. CITY OR TOWN Henderson					
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Johes Rd.					
14. FATHER'S NAME FIRST Ellis Bolt MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST Laura Hylton MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-05-9621		17. INFORMANT ADDRESS Hospital Records - Chestertown, Maryland			

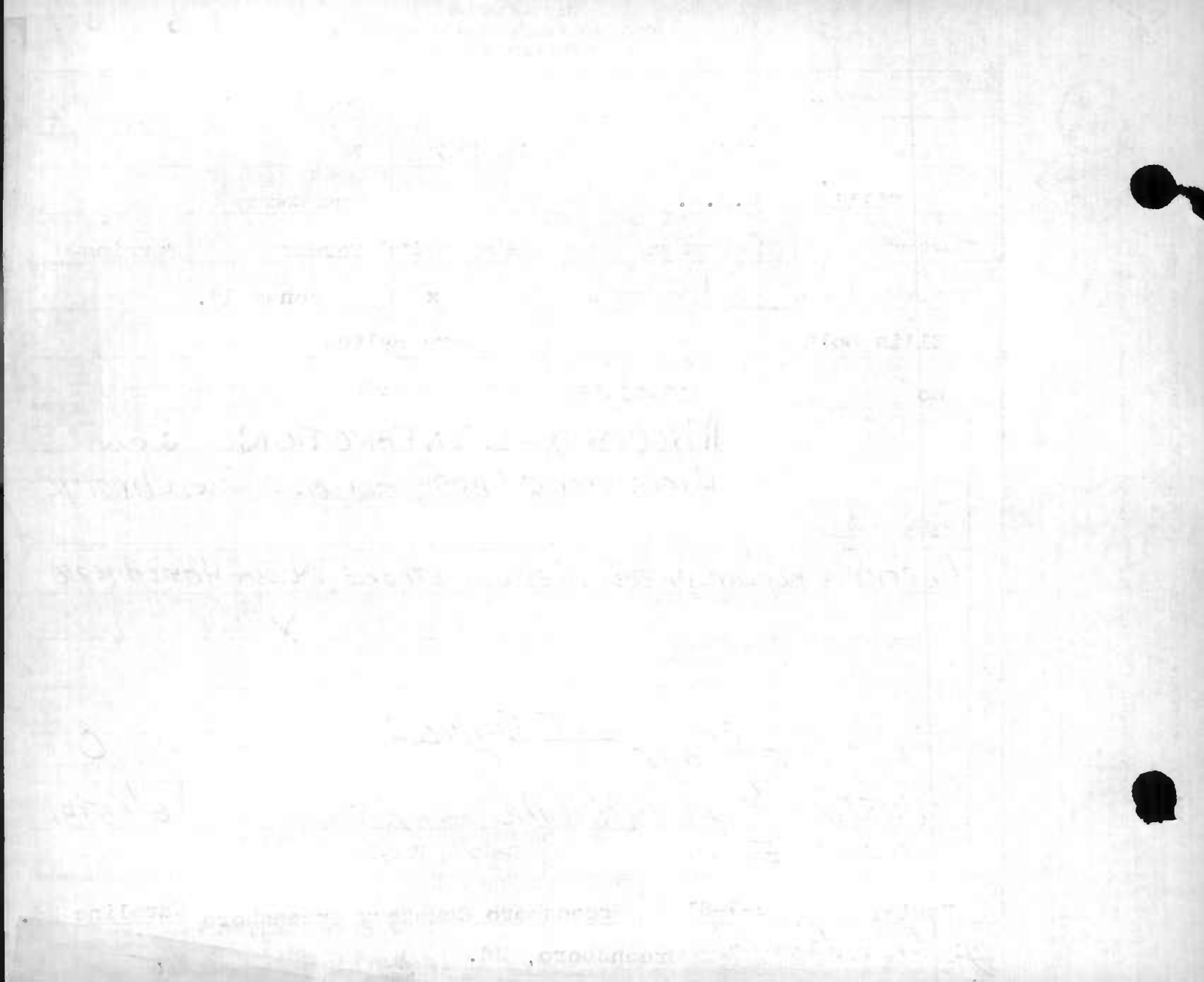
18. CAUSE OF DEATH (Enter only one cause applying for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:4100
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
(b) HYPERTENSIVE CARDIOVASCULAR DISEASE
(c) DUE TO, OR AS A CONSEQUENCE OFAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHacute
chronicPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
CEREBROVASCULAR DISEASE; PREVIOUS STROKE VALVULAR HEART DISEASE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) CT 1/21/77 CT		21f. LOCATION (CITY OR TOWN COUNTY STATE) Denton, Maryland			
22a. I certify that (I) (this hospital) attended the deceased from June 4 1981, to June 4 1981, that (I) (we) last saw the deceased alive on June 4 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Christian Jensen M.D.				22c. DATE SIGNED 6/05/81		22d. ADDRESS Denton, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-7-81		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery Greensboro		23d. LOCATION CITY OR TOWN COUNTY STATE Caroline Md.	
24. FUNERAL DIRECTOR John E. Boulaie ADDRESS Greensboro, Md.				25a. DATE REC'D. BY REGISTRAR JUN 10 1981		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	6	1	3	8
1- FOR REGISTRAR										7a, Film G557 7/9/81 kam					
1 DECEASED NAME (TYPE OR PRINT) HAROLD WARE BROOKS										2a DATE OF DEATH MONTH DAY YEAR June 17, 1981				2b HOUR 6:30 AM	
3 SEX male			4 RACE white			5 DATE OF BIRTH MONTH DAY YEAR Aug. 5, 1917			6 AGE (IN YEARS LAST BIRTHDAY) 63			7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			9b CITIZEN OF WHAT COUNTRY? USA			9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Kent				MD.		
10 CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 306 Kent St (at home)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Doctor			12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Md.			13b COUNTY Kent			13c CITY OR TOWN Chestertown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 306 Kent St.			
14 FATHER'S NAME FIRST MIDDLE LAST Robert P Brooks						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Ware									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes						16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 2 125 07 0295			17 INFORMANT ADDRESS Mrs. Anne Brooks 306 Kent St. Chestertown, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Kidney CARCIN on 14 (Renal cell CA) 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) metastases to Liver & Bones DUE TO, OR AS A CONSEQUENCE OF (c) & Liver.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 6/16/81 19 81 , to 6/17/81 19 81 , that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE Patrick A. Molony								DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 6/17/81			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony								22e ADDRESS Chestertown, Md. 20620							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b DATE 6/18/81		23c NAME OF CEMETERY OR CREMATORY Silverbrook Cermatary				23d LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.					
24 FUNERAL DIRECTOR John Wells								24a ADDRESS Chestertown, Md.				24b DATE REG'D BY REGISTRAR JUN 22 1981			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 6 1 8 9				
1. FOR STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	A*
Albert E. Dennis								June 2, 1981					8:30	M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 74 HRS				
male		white		9/3/1907		73		MONTHS		DAYS		HOURS		MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.
Ohio		USA				Kent								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown		300 Water St. (At Home)		Col. U.S. Army										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md.		Kent		Chestertown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		300 Water St.						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST				
Vern		Dennis				Fanny		Alexander						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		300 ADDRESS		Water St.						
yes		WW 2		176 32 3499		Ruth Dennis		Chestertown, Md.		21620				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of rectum</u> <u>1541</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
1979		Ca RECTUM		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>5/30</u> 19 <u>81</u> , to <u>6/2</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>C. Gottfried Baumann</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann		22e. ADDRESS Chestertown, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/5/81		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.								
24. FUNERAL DIRECTOR NAME <u>G. Willis Wells</u>		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 5 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 9 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Minnie Esther Downey			2a. DATE OF DEATH MONTH DAY YEAR June 23, 1981			2b. HOUR 4:24A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 8, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Louis Hendrick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmyra Betz			13e. STREET ADDRESS Haven Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-03-5901		17. INFORMANT Hospital Records, Chestertown, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hr. 9 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>June 22</u> , 19 <u>81</u> , to <u>June 23</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>June 23</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Wayne D. Benjamin M.D.</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/25/81</u>		
22e. ADDRESS Chestertown, Maryland 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-26-81		23c. NAME OF CEMETERY OR CREMATORY WESLEY CHAPEL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ROCK HALL KENT MD.		
24. FUNERAL DIRECTOR NAME HELLENBEIN-HUBBARD FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR JUN 29 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

RECEIVED OCT 20 1905

100

100

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Handwritten text at the bottom of the page, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH	
			Cora Beal Dudley		June 26, 1981	
3. SEX			4. RACE		5. DATE OF BIRTH	
Female			White		February 5, 1903	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland			United States		78	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Chestertown			Kent & Queen Anne's Hospital		Kent	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Housewife			Home			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	
Maryland			Kent		Chestertown	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
Thomas Jefferson Haddaway			Sarah Hollingsworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT	
No			213-42-0500		John T. Denbeck, Chestertown, Md. 21620	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE			Cardiac Arrest			
4275			DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) Coronary artery disease Coronary Artery Disease			
			DUE TO, OR AS A CONSEQUENCE OF			
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
Metabolic Acidosis, Renal impairment, NIDD diabetes, Hyperpotassemia						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
			HOUR A.M. MONTH DAY YEAR			
			P.M. 19			
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 25, 1981, to June 26, 1981, that (I) (we) lost						
saw the deceased alive on June 26, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE			DEGREE		22c. DATE SIGNED	
Robert W. Farr M.D.					June 26, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			
Robert W. Farr M.D.			Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial			June 29, 1981		Chesterfield	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Barton Bros.			JUL 1 1981			
James H. Barton, Jr., Centreville, Md. 21617						



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 9 2

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) VERA G. GRANGER		2a DATE OF DEATH MONTH DAY YEAR June 30, 1981		2b HOUR 5:43 PM	
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 9/28/1900		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10 CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Ctr		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Md.		13b COUNTY Queen Anne	13c CITY OR TOWN Chestertown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS RFD
14 FATHER'S NAME FIRST MIDDLE LAST John P. Boring		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Schaefer			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212 14 9755		17 INFORMANT ADDRESS Webster Bierman Chestertown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Long standing coronary artery disease</i>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 6/30, 1981, to 6/30, 1981, that (I) (we) lost saw the deceased alive on 6/30, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b SIGNATURE <i>Robert W. Farr</i>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7/1/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr		22e ADDRESS Chestertown, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 7/2/81	23c NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Hampsted Md.	
24 FUNERAL DIRECTOR NAME <i>J. Wells Wells</i>		ADDRESS Chestertown, Md.		25a DATE REC'D. BY REGISTRAR JUL 6 1981	25b REGISTRAR'S SIGNATURE <i>Robert W. Farr</i>

BP

October 1900

For a long time in the past

W. H. Brown

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

WALLACE

GRAVES

20. DATE KNOWN
OF DEATH ☐ ESTI-
MATED ☐ 6/16/81 4⁰⁰ P M3. SEX
Male4. RACE
Black5. DATE OF BIRTH
MONTH DAY YEAR
12/2/19086. AGE (IN YEARS)
LAST BIRTHDAY YRS.
72IF UNDER 1 YR.
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN.21. DATE
PRONOUNCED
DEAD 6/16/81 8⁰⁰ P M7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Kent Co. Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Kent Co.

MD.

10. CITY OR TOWN OF DEATH

Nr. Chestertown

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

At Home RFD # 3

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Waterman retired

12b. KIND OF BUSINESS
OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Md.

13c. COUNTY

Kent

13d. CITY OR TOWN

Chestertown

13e. INSIDE CITY LIMITS?

YES ☐ NO ☒

13f. STREET ADDRESS

RFD # 3

14. FATHER'S NAME
FIRST MIDDLE LAST

Joseph H. Graves

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

Geraldine Walley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

219 14 2828

17. INFORMANT

Margaret Thompson

ADDRESS RFD 3 Bx 349

Chestertown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

A S C V D

IMMEDIATE CAUSE (a)

4292

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.ACTUAL
SIGNATURE

Robert W. Farr

M.D.

MEDICAL EXAMINER

DATE
SIGNED

6/16/81

EXAMINER'S NAME
(TYPE OR PRINT)

Kent County Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

6/20/81

23c. NAME OF CEMETERY OR CREMATORY

Emmanuel Cemetery

23d. LOCATION
CITY OR TOWN

nr Chestertown, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR
(NAME)

James Perkins

Rock Hall, Md.

25a. DATE REC'D. BY REGISTRAR

JUN 22 1981

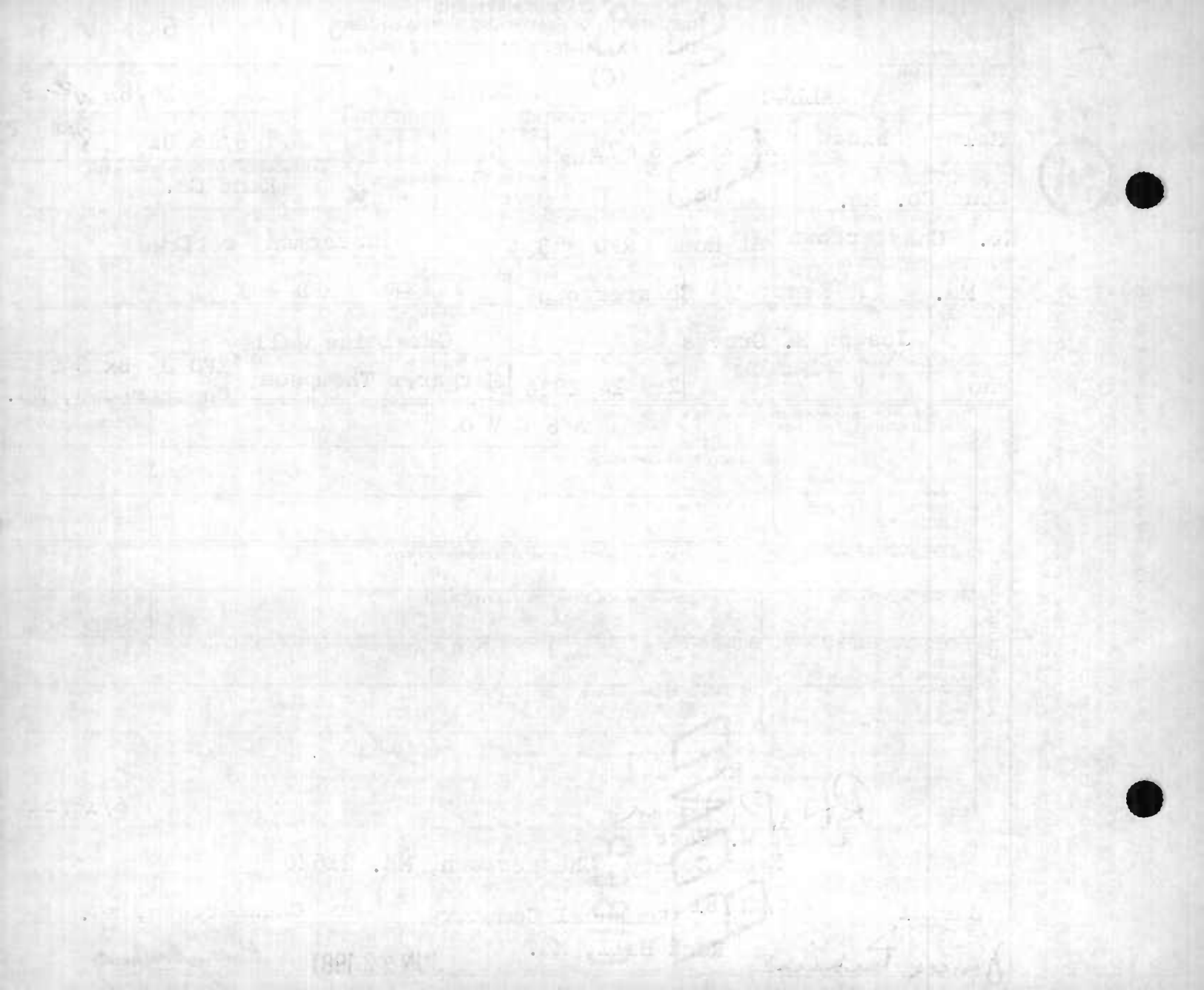
25b. REGISTRAR'S SIGNATURE

Robert W. Farr

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DEATH CERTIFICATE IS REQUIRED. PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE VITAL RECORDS DIVISION.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST.,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 1 9 4	
FOR 1- STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) ROBERT JOHN HITCHNER			2a. DATE OF DEATH MONTH DAY YEAR June 24^m 1981		2b. HOUR 5:30^M
3. SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR July 2, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent kent MD.	
10 CITY OR TOWN OF DEATH Betterton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home 2nd & Glenn Sts		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Kent	13c. CITY OR TOWN Betterton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2nd & Glenn Sts.
14 FATHER'S NAME FIRST MIDDLE LAST Herbert Hitchner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Behenke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 180 01 8452		17 INFORMANT ADDRESS Margaret Hitchner Betterton, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of rectum 1541 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-5 , 19 76 , to 6-23 , 19 81 , that (I) (we) lost saw the deceased alive on 6-23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.					
22b. SIGNATURE Wayne D. Benjamin		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/24/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin		22e. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/27/81		23c. NAME OF CEMETERY OR CREMATORY Edgewood Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Mill Pa.		23e. DATE REC'D BY REGISTRAR JUN 30 1981		23f. REGISTRAR'S SIGNATURE John H. Wells	
24 FUNERAL DIRECTOR NAME John H. Wells		ADDRESS Chestertown, Md.			

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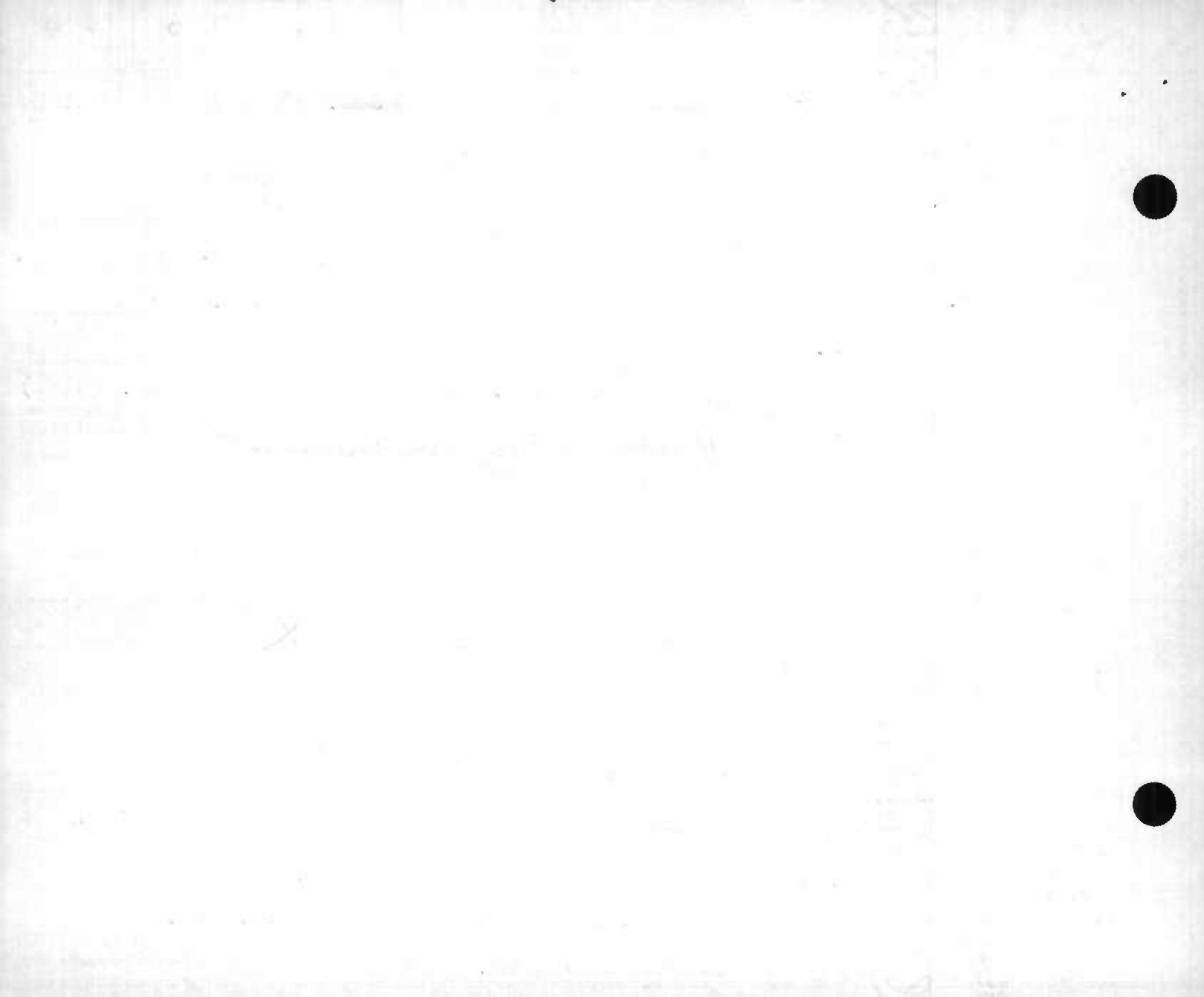
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 6 1 9 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERIC ARTHUR LAWS				2a. DATE OF DEATH MONTH DAY YEAR June Jan. 20, 1981		2b. HOUR 12:30	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 22, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10 CITY OR TOWN OF DEATH Betterton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Co.		12b. KIND OF BUSINESS OR INDUSTRY Plant Dept.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Kent Betterton		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS Bay Ave.			
14 FATHER'S NAME FIRST MIDDLE LAST Federic A. Laws				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 163 01 0778		17 INFORMANT ADDRESS Mrs. Olwen Laws Betterton, Md. (Wife)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Possible ruptured aortic aneurysm - 4415 DUE TO, OR AS A CONSEQUENCE OF (b) AGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1976 , 19____, to 6-20 , 19 81 , that (I) (we) last saw the deceased alive on 6-20 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert W. Farr				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/20/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr				22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (PRECISE) Cremation		23b. DATE 6/22/81		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wilm. Del.	
24. FUNERAL DIRECTOR NAME ADDRESS J. Willis Wells Chestertown, Md.				25a. DATE REC'D BY REGISTRAR JUN 23 1981		25b. REGISTRAR'S SIGNATURE John J. McBratney	

BP

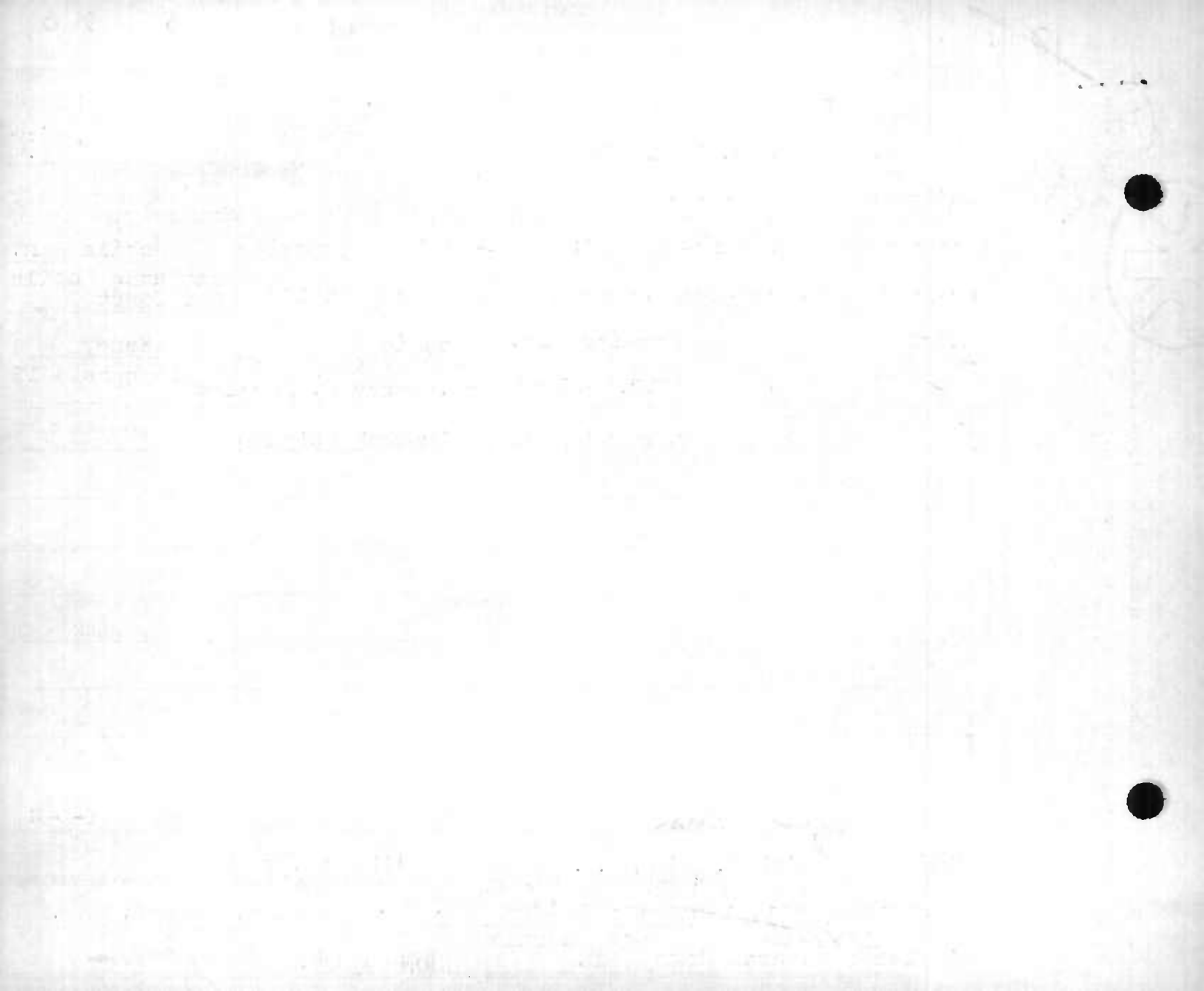


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16196	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hurl (nmn) Perkins Jr.							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 7 1981		2b. HOUR 1:00 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 11, 22 59 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 7 1981		7d. HOUR P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.		
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DUCK NECK CAMPGROUNDS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trucking		12b. KIND OF BUSINESS OR INDUSTRY Mobile Hms.		
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Hanover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Chesapeake Mobile Lot 156 Home Court		
14. FATHER'S NAME FIRST MIDDLE LAST Hurl Perkins Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Kaney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT (Wife) Mrs. Betty J. Perkins			ADDRESS Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) Assistant				DATE SIGNED 6-8-81			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 11, 1981			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, MD.		
24. FUNERAL DIRECTOR NAME Singleton Funeral Home				ADDRESS Glen Burnie MD.				25a. DATE REC'D. BY REGISTRAR JUN 11 1981		25b. REGISTRAR'S SIGNATURE <u>History McBrady</u>	

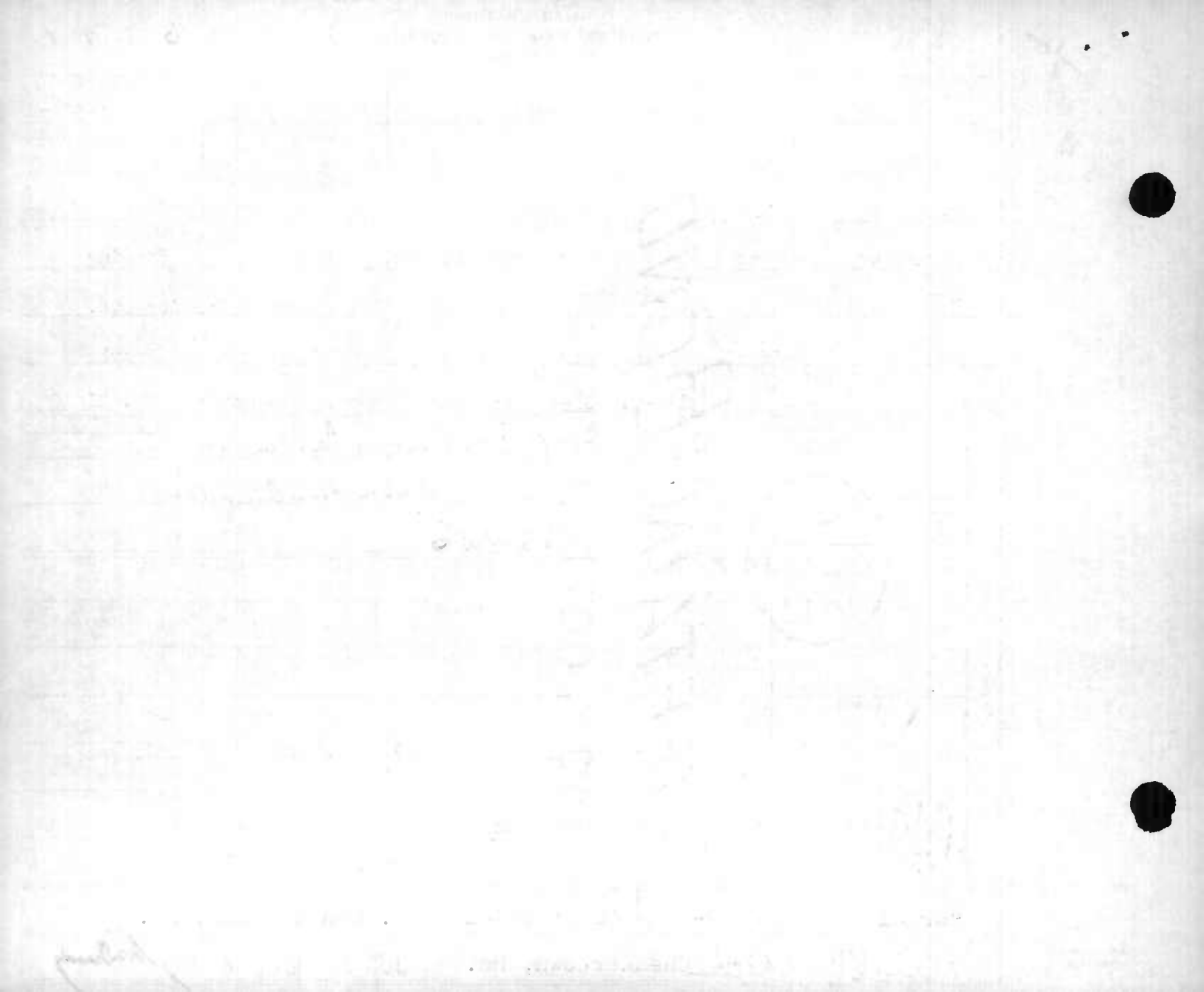


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 6 1 9 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Kent Sparks Price						2a. DATE OF DEATH MONTH DAY YEAR June 2, 1981			2b. HOUR 1:50 pm		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3 Box 37 Collins Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST John Medford Price				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Richardson Sparks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-07-035-9		17. INFORMANT ADDRESS Hospital Records-Chestertown, MD. 21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Resp Failure & pneumonia</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ascaris</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 26</u> , 19 <u>81</u> , to <u>June 2</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Patrick A. Molony</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT)						22c. DATE SIGNED <u>June 5 1981</u>					
23a. BURIAL, CREMATION, REMOVAL (IF ANY) Burial						23b. DATE 6/6/81		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville, Md.	
24. FUNERAL DIRECTOR <u>William Wells</u> NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR JUN 5 1981		25b. REGISTRAR'S SIGNATURE <u>Patrick A. Molony</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 9 8

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Elmer Reed			2a. DATE OF DEATH MONTH DAY YEAR June 30, 1981		2b. HOUR 10:45 P_M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 8, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Highway Administrator-State		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Henry Reed				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie E. McDonald				17. INFORMANT ADDRESS Hospital Records, Chestertown, Maryland 21620	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-36-6162							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to Ventricular fibrillation 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Myocardially-dilated heart. Bacteremia. Congestive failure.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 26, 1981 to June 30, 1981 , that (I) (we) lost saw the deceased alive on June 30, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Farr				DEGREE Attending Physician				22c. DATE SIGNED 7/1/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.				22e. ADDRESS Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/81		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.			
24. FUNERAL DIRECTOR NAME William Wells				25a. DATE REC'D. BY REGISTRAR JUL 6 1981		25b. REGISTRAR'S SIGNATURE Robert W. Farr			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1851

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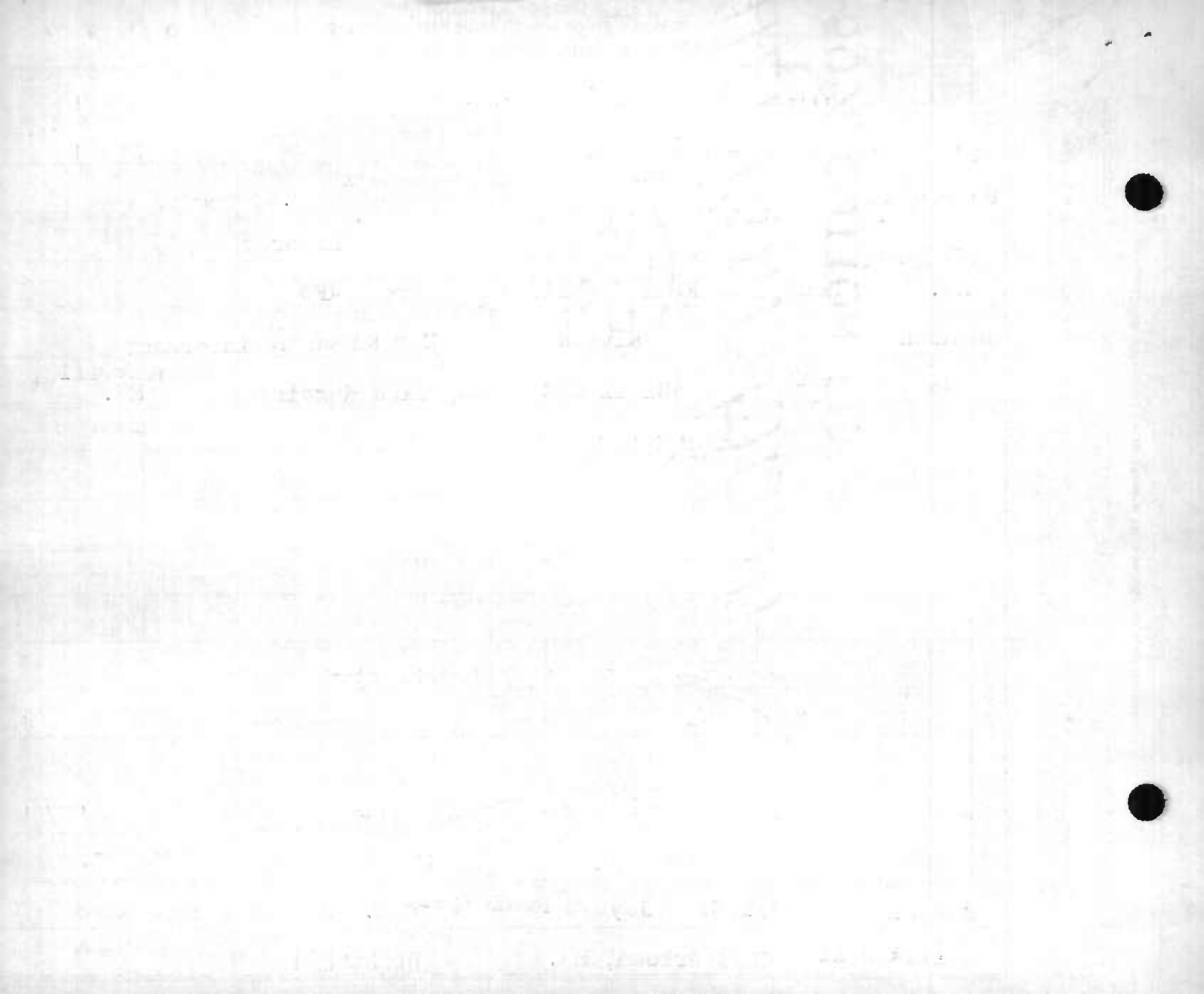
1851

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16199									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Cordova Rivera										20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 25 1981										26. HOUR M 12:59									
3. SEX Male		4. RACE Hispanic		5. DATE OF BIRTH MONTH DAY YEAR 11/14/56		6. AGE (IN YEARS) (LAST BIRTHDAY) 24 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 25 1981		24. HOUR M 12:59																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico				7b. CITIZEN OF WHAT COUNTRY? Puerto Rico USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Kent County, MD																	
10. CITY OR TOWN OF DEATH Crumpton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 290				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. COUNTY Kent										13c. CITY OR TOWN Kennedyville									
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS RFD																			
14. FATHER'S NAME FIRST MIDDLE LAST unknown Rivera										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known by informant																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no										16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -										17. INFORMANT ADDRESS Kennedyville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:45xx 6 25 1981										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road										21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 290 Crumpton Kent Md.									
22a. I certify that I took charge of the remains described above, and on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE Thomas D. Smith, M.D.										TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER										DATE SIGNED 6/25/81									
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.										ADDRESS 111 Penn St. Balto, MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 7/1/81										23c. NAME OF CEMETERY OR CREMATORY Jayuya Municipal Cem.									
23d. LOCATION CITY OR TOWN COUNTY STATE Jayuya Puerto Rico																													
24. FUNERAL DIRECTOR NAME Willis Wells										ADDRESS Chestertown, Md.										25a. DATE REC'D. BY REGISTRAR JUN 30 1981		25b. REGISTRAR'S SIGNATURE [Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 1 6 2 0 0		
1- FOR STATE REGISTRAR			REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) BERTHA MATHIDA SMITH			2a. DATE OF DEATH MONTH DAY YEAR JUNE 8, 1981		2b. HOUR 11:00 AM		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR NOV. 16, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD.	
10. CITY OR TOWN OF DEATH Chesterdown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AT HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b. KIND OF BUSINESS OR INDUSTRY VARIOUS	
13a. STATE MD.		13b. COUNTY KENT		13c. CITY OR TOWN Chesterdown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Goldsporough		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECILIA BROWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
17a. SOCIAL SECURITY NO. 215-20-0099		17. INFORMANT ADDRESS MRS. MARJORIE E. SMITH, R.F.D. #3 CHESTERDOWN, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 4/28 19 80 to June 19 81 , that (I) (we) lost saw the deceased alive on 4/28 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE G. Gottfried Baumann				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/9/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. GOTTFRIED BAUMANN				22e. ADDRESS Chesterdown, MD. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-12-1981		23c. NAME OF CEMETERY OR CREMATORY JANES CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE Chesterdown Kent MD.	
24. FUNERAL DIRECTOR NAME Anneth Wald				24b. ADDRESS Chesterdown, MD.			
24c. DATE REC'D. BY REGISTRAR JUN 15 1981				24d. REGISTRAR'S SIGNATURE [Signature]			

